

Individual Application



Reason for Application (Check one)

- New plan/policy
 Change your current plan/policy
 Add dependent(s) to existing plan/policy

Indicate subscriber's ID Number for existing Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy: _____

NOTE: If you are adding a dependent or changing benefit options the effective date will always be the first of the month following approval.

Effective date requested: If your application is approved your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: ____/____/____ **MM/DD/YYYY**

IMPORTANT: PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION.

Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-800-333-0912.

1. Primary Applicant Information (Please print)

Last Name		First Name		M.I.	Social Security or ID No.		
Home Address (Must be complete)				City		State	ZIP Code
Mailing Address (If different than above) or P.O. Box Private Mail Box (PMB) No.				City		State	ZIP Code
Daytime Phone Number		Evening Phone Number		Fax Number		E-mail Address	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership		Language Choice (Optional) <input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Chinese (ZHO) (C/M) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL) <input type="checkbox"/> Other (W09) _____					
<input type="checkbox"/> Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (Section 9).							
Please provide your communication method of choice for all underwriting correspondence during the review of your application: <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Mail							

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy

Family members 19 years of age and older may select a different medical plan/policy by using the FamilyElectSM option. To do so, refer to the 4-digit codes in parentheses below and indicate your medical benefit options in Section 3B for each family member. **PLEASE NOTE:** A dependent child under the age of 19 must choose the same plan as the parent/legal guardian over the age of 19.

If you want one medical plan/policy for all family members, please select a box below. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will enroll all eligible family members unless otherwise instructed.

I, the Applicant, request that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company not enroll any eligible applicants unless ALL family members qualify.

If you are choosing **Dental** coverage or **Term Life Insurance**, please complete the appropriate sections that follow.

Medical Benefit Options

- | | | | |
|-----------------------------------|--|---|---|
| Tonik | <input type="checkbox"/> 5000 (06BK) | | |
| ClearProtection Plus | <input type="checkbox"/> 1000 (06B3) | <input type="checkbox"/> 3300 (06B4) | <input type="checkbox"/> 5000 (06B5) |
| CoreGuard Plus | <input type="checkbox"/> 750 w Facility Copay (06B6) | <input type="checkbox"/> 1500 w Facility Copay (06B7) | <input type="checkbox"/> 2500 w Facility Copay (06B8) |
| | <input type="checkbox"/> 3500 (06B9) | <input type="checkbox"/> 5000 (06BA) | <input type="checkbox"/> 7500 (06BB) |
| | <input type="checkbox"/> 10000 (0ADX) | | |

Agent Name/TIN

Health care plans provided by Anthem Blue Cross. Insurance plans provided by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark. © The Blue Cross name and symbol are registered marks of the Blue Cross Association.



2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy – continued

Primary Applicant's Name _____

Medical Benefit Options

- | | | | |
|------------------------------|---|---|---|
| PPO Share | <input type="checkbox"/> 1000 (06BL) | <input type="checkbox"/> 3500 (06BX)* | <input type="checkbox"/> 5000 (06BZ)* |
| | <input type="checkbox"/> 7500 (06BY)* | | |
| SmartSense Plus | <input type="checkbox"/> 1000 - 70% (01KB) | <input type="checkbox"/> 1000 - 70% w Rx Upgrade (01KF) | <input type="checkbox"/> 2000 - 70% Standard Rx (01KC) |
| | <input type="checkbox"/> 2000 - 70% w Rx Upgrade (01KG) | <input type="checkbox"/> 3500 - 70% Standard Rx (01KD) | <input type="checkbox"/> 3500 - 70% w Rx Upgrade (01KH) |
| | <input type="checkbox"/> 6000 - 70% Standard Rx (01KE) | <input type="checkbox"/> 6000 - 70% w Rx Upgrade (01KJ) | |
| Premier Plus | <input type="checkbox"/> 1000 - 75% (06BD) | <input type="checkbox"/> 1500 - 75% (06BE) | <input type="checkbox"/> 2500 - 75% (06BF) |
| | <input type="checkbox"/> 3500 - 75% (06BG) | <input type="checkbox"/> 5000 - 75% (06BH) | <input type="checkbox"/> 6000 - 75% (06BJ) |

HSA Compatible Plans

- | | | | |
|--|---|---|---|
| Lumenos HSA (no Maternity) | <input type="checkbox"/> 1500 (06BN) | | |
| Lumenos HSA (with Maternity) | <input type="checkbox"/> 5000 (06BP) | | |
| Lumenos Plus HSA – Individual Only Policies | <input type="checkbox"/> 3000 – 100% (01KK) | <input type="checkbox"/> 4500 – 100% (01KL) | <input type="checkbox"/> 5950 – 100% (01KM) |
| Lumenos Plus HSA – Family Policies | <input type="checkbox"/> 3500 – 100% (01KN) | <input type="checkbox"/> 5500 – 100% (01KP) | <input type="checkbox"/> 7500 – 100% (01KQ) |
| | <input type="checkbox"/> 11,900 - 100% (01KR) | | |

If you have chosen a Health Savings Account (HSA) product, choose the following:

- Yes**, I would like to establish an HSA. Please forward my information to Anthem Blue Cross' banking partner.
- No, I DO NOT** want to establish an HSA. Please **DO NOT** forward my information to Anthem Blue Cross' banking partner.

HMO Plans

- | | | | |
|------------------|---|--|---|
| HMO | <input type="checkbox"/> Select HMO (06C2)* | <input type="checkbox"/> HMO Saver (06C1)* | <input type="checkbox"/> Individual HMO (06C0)* |
|------------------|---|--|---|

Other To apply for a plan/policy not listed, write in the name here:

* These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance. Products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance.



2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy – continued

Primary Applicant's Name _____

Dental Benefit Options

PPO Plans Dental Blue Basic (01PU) Dental Blue Enhanced (01PW)

 Other _____

Tonik Enhanced Dental PPO Dental (DR53)

DHMO Plan Dental SelectHMO (ZE7N)†

Dental HMO Office Number _____

Dental Select HMO plans are offered by Anthem Blue Cross. Dental Blue plans are offered by Anthem Blue Cross Life and Health Insurance Company.

† If you are enrolling in any of the Anthem Blue Cross Dental SelectHMO plans, please enter the number of the Dental Office you have chosen in the space above. If I purchase optional dental benefits, I understand that I may have a waiting period for the coverage.



3. List ALL Applicants for Medical/Dental Benefit Options

Primary Applicant's Name _____

All approved applicants will be assigned the same effective date of coverage as long as there is no break in coverage for any applicant.

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn 26). (List all dependents beginning with the eldest.)										3A. For HMO Use Only Choose a provider for each family member by calling 1-866-297-7647 or from the Provider Directory, which can be found at www.anthem.com/ca			3B. Indicate Medical or Dental Benefit Option Code from Section 2 for each family member (if different)
Sex	Last Name	First	M.I.	Social Security or ID No.*	Age	Birthdate mm/dd/yy	Height ft. in.	Weight lbs.	Select Coverage	PMG/ IPA*	Primary Care Physician (PCP)	Current Patient	
<input type="checkbox"/> M <input type="checkbox"/> F	Primary Applicant					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse/Domestic Partner					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 2					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 3					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 4					/ /			<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

My domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

If a family member's last name is different from the primary applicant's last name, please explain: _____

INSTRUCTIONS:

Primary Applicant - please complete and return Section 6, Health History page 7a (Primary Applicant) through page 10a (Primary Applicant).

Spouse/Domestic Partner - please complete and return Section 6, Health History page 7b (Spouse/Domestic Partner) through page 10b (Spouse/Domestic Partner).

Dependent 1 - please complete and return Section 6, Health History page 7c (Dependent 1) through page 10c (Dependent 1).

Dependent 2 - please complete and return Section 6, Health History page 7d (Dependent 2) through page 10d (Dependent 2).

If there are no Spouse/Domestic Partner, Dependent 1, or Dependent 2 applicants, you do not need to return Section 6, Health History pages indicated for those applicants.

If there are additional Dependent applicants (Dependent 3 or Dependent 4), please complete copies of Section 6, Health History, write by the page number if it is Dependent 3 or Dependent 4 and return with the other completed sections of the application.

Has any person listed on this application lived (not traveled) outside the U.S. for the past three (3) consecutive months? Yes No

If Yes, who? _____

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? Yes No,

If No, who? _____

Are all applicants listed on this application United States citizens? Yes No

If No, who _____

and how many months/years have they resided in the United States? _____ years and _____ months

* The social security number provided is for internal use only. PMG = Participating Medical Group, IPA = Independent Practice Association



4. Anthem Blue Cross Life and Health Term Life Insurance
 (Products regulated by the California Department of Insurance)

Primary Applicant's Name _____

TERM LIFE BENEFIT OPTIONS

Applicants and/or any dependents who are approved for medical coverage will also qualify for an Anthem Blue Cross Life and Health Insurance Term Policy at an **additional charge**.

Applicants or dependents under the age of one year are not eligible for term life insurance.

If the applicant has existing life coverage or annuity, does the applicant intend to replace existing life insurance or an existing annuity with the Life policy applied for here? Yes No
 If you answered "Yes" to the question just above, please do not discontinue, change, or borrow against any existing life insurance or annuity contracts. Such actions are regarded as "replacement," and our policy is not designed or intended to replace existing coverage. Furthermore, if you replace existing coverage and we decline your application for life insurance, you may be left with diminished or no coverage. If you have questions about replacement, ask your agent.

DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.

Family Member Name	Birthdate mm/dd/yy	Amount of Benefit	Beneficiary Name	Relationship	Allocation	% Allocation
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$50,000			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	% %
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$50,000			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	% %
	/ /	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$50,000			<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	% %

NOTE: Amounts greater than or equal to \$50,000 are not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to \$30,000. If beneficiary is not listed and policy is issued, death benefits will be paid in accordance with the Beneficiary Provision in the Policy.

See Section 7 (Application Understandings, Conditions and Agreements) for additional terms.

5. Prior Insurance History

Please answer ALL of the following questions.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company credits prior coverage toward the preexisting period for those applicants who apply for coverage within 63 days after termination of qualifying prior coverage. To obtain credit toward the preexisting waiting period, please complete the following questions. Pre-existing condition limitations do not apply to applicants under the age of nineteen (19) unless you are adding an applicant under the age of 19 to your coverage which was effective prior to March 23, 2010.

Pre-existing Conditions: For applicants age nineteen (19) and older, no payment will be made for services or supplies for the treatment of a Preexisting Condition during a period of six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if you become eligible for coverage within 62 days of termination of your qualifying prior coverage (exclusive of any waiting or affiliation period), and you apply with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company no longer than 63 days after termination of your qualifying prior coverage. HMO medical plans do not have a preexisting waiting period.

1. Are any applicants eligible for Medicaid or Medicare? Yes No

If yes, who? _____

Please provide your Medicare or Medicaid Number _____

2. Has any applicant been previously insured by a Anthem Blue Cross plan or Anthem Blue Cross Life and Health Insurance policy? Yes No

If yes, indicate Certificate No. _____

3. Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits or unable to work due to disability or receiving Workers' Compensation? Yes No



5. Prior Insurance History – continued

Primary Applicant's Name _____

4. Do you currently have coverage? Yes No
If yes, please provide the following information for each applicant below.
If no, has any applicant had coverage in the last 63 days? Yes No
 If you answered "Yes", please provide the following information for each applicant:

Applicant Name(s) OR <input type="checkbox"/> All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other

Reason for Cancellation Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Yes No

Applicant Name(s) OR <input type="checkbox"/> All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other

Reason for Cancellation Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Yes No

The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Coverage

For HIPAA applicants, the effective date is determined by the date we receive payment. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

While I understand that I am applying for an Individual plan/policy, if I do not qualify, I would like to be considered for benefits under HIPAA. Yes No

If yes, please provide the following information:

* For HIPAA, I understand that no underwriting is required and rates may be higher than for the Individual Plans/Policies. If I qualify, please offer the HIPAA coverage and have complete details sent to me regarding my options and rates for HIPAA. If you have any questions regarding the HIPAA application process, please contact Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company customer service at 1-800-333-0912.

Name of Applicant(s) requesting HIPAA _____

1. Are you currently covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health insurance benefits? Yes No
If yes, you are not eligible for HIPAA.

2. Have you had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan, ("employer" includes a governmental entity or church), that ended within the last 63 days for a reason other than fraud or non-payment of premium? Yes No

If yes, you will be asked to provide documentation of such coverage, preferably the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the following:

_____/_____/_____
 Name of Applicant Effective Date (Mo/Day/Yr) End Date (Mo/Day/Yr)

 Name of insurance carrier(s): Phone No.

If no, you are not eligible for HIPAA.

3. Were you eligible for continuing coverage under COBRA or Cal-COBRA? Yes No

If yes, please provide the following: _____
 Effective Date (Mo/Day/Yr) End Date (Mo/Day/Yr)

If no, please explain: _____

If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA.



6. Health History

Primary Applicant's Name _____

Each applicant must complete a separate Health History Questionnaire. Applicants for HIPAA only do not need to complete Section 6. HIPAA law guarantees coverage.

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE		YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A. Headaches requiring prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Sleep apnea/breathing difficulties while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. If you answered yes to 4a, check any reasons that apply				D. Recurrent fainting, weakness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Paralysis or chronic limb weakness or numbness/tingling in limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Due to birth control method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Due to breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G. Increased/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hysterectomy or menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H. Low or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have retained hardware, prosthesis or implants?				J. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K. Heartburn (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eye/limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M. Recurrent diarrhea and/or recurrent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any other prosthesis or implant (other than dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O. Blood, sugar, and/or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				P. Recurrent pain (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Q. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				R. Mass, cyst(s), or lump(s) in any body part including breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Male infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Female fertility/infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney, bladder or prostate disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Psoriasis, rosacea, acne or skin disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Cataract, glaucoma, eye or ear disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Minor depression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Anxiety/panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hepatitis C, D, E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hepatitis non A - E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you used marijuana within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(if yes, check appropriate box)			
<input type="checkbox"/> less than 4 times per month			
<input type="checkbox"/> 5-7 times per month			
<input type="checkbox"/> 8 or more times per month			

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever used illegal intravenous (IV) drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)			
<input type="checkbox"/> 0 per week <input type="checkbox"/> 1-14 per week <input type="checkbox"/> 15-26 per week <input type="checkbox"/> 27 or more per week			



6C. Medical Details

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					



6C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care								
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____								
Name of Condition/Illness			Address		Suite No.						
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City		State						
			Phone Number		FAX Number (Optional)						
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Do not understand the medical term(s) used in the question</td> <td><input type="checkbox"/> Do not understand the question</td> </tr> <tr> <td><input type="checkbox"/> Do not know if you have the listed condition or symptom</td> <td><input type="checkbox"/> Had the listed condition or symptom but cannot remember when</td> </tr> <tr> <td><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized</td> <td><input type="checkbox"/> Do not recall or remember the information</td> </tr> </table> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p>						<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question	<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when	<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information
<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question										
<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when										
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information										

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care								
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____								
Name of Condition/Illness			Address		Suite No.						
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City		State						
			Phone Number		FAX Number (Optional)						
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Do not understand the medical term(s) used in the question</td> <td><input type="checkbox"/> Do not understand the question</td> </tr> <tr> <td><input type="checkbox"/> Do not know if you have the listed condition or symptom</td> <td><input type="checkbox"/> Had the listed condition or symptom but cannot remember when</td> </tr> <tr> <td><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized</td> <td><input type="checkbox"/> Do not recall or remember the information</td> </tr> </table> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p>						<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question	<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when	<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information
<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question										
<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when										
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information										

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Physician or Hospital	
					Name	Phone
					Name	Phone
					Name	Phone
					Name	Phone
					Name	Phone
					Name	Phone
					Name	Phone
					Name	Phone

Please check box if an additional sheet(s) of paper has been completed for this section.



When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE		YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A. Headaches requiring prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Sleep apnea/breathing difficulties while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. If you answered yes to 4a, check any reasons that apply				D. Recurrent fainting, weakness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Paralysis or chronic limb weakness or numbness/tingling in limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Due to birth control method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Due to breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G. Increased/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hysterectomy or menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H. Low or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have retained hardware, prosthesis or implants?				J. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K. Heartburn (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eye/limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M. Recurrent diarrhea and/or recurrent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any other prosthesis or implant (other than dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O. Blood, sugar, and/or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				P. Recurrent pain (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Q. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				R. Mass, cyst(s), or lump(s) in any body part including breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Male infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Female fertility/infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney, bladder or prostate disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Psoriasis, rosacea, acne or skin disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Cataract, glaucoma, eye or ear disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Minor depression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Anxiety/panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hepatitis C, D, E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hepatitis non A - E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you used marijuana within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(if yes, check appropriate box)			
<input type="checkbox"/> less than 4 times per month			
<input type="checkbox"/> 5-7 times per month			
<input type="checkbox"/> 8 or more times per month			

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever used illegal intravenous (IV) drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)			
<input type="checkbox"/> 0 per week <input type="checkbox"/> 1-14 per week <input type="checkbox"/> 15-26 per week <input type="checkbox"/> 27 or more per week			

(Spouse/Domestic Partner)



6C. Medical Details

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
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(Spouse/Domestic Partner)



6C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care							
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____							
Name of Condition/Illness			Address _____ Suite No. _____							
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City	State						
			Phone Number	FAX Number (Optional)						
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Do not understand the medical term(s) used in the question</td> <td><input type="checkbox"/> Do not understand the question</td> </tr> <tr> <td><input type="checkbox"/> Do not know if you have the listed condition or symptom</td> <td><input type="checkbox"/> Had the listed condition or symptom but cannot remember when</td> </tr> <tr> <td><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized</td> <td><input type="checkbox"/> Do not recall or remember the information</td> </tr> </table> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p>					<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question	<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when	<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information
<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question									
<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when									
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information									

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care							
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____							
Name of Condition/Illness			Address _____ Suite No. _____							
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City	State						
			Phone Number	FAX Number (Optional)						
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Do not understand the medical term(s) used in the question</td> <td><input type="checkbox"/> Do not understand the question</td> </tr> <tr> <td><input type="checkbox"/> Do not know if you have the listed condition or symptom</td> <td><input type="checkbox"/> Had the listed condition or symptom but cannot remember when</td> </tr> <tr> <td><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized</td> <td><input type="checkbox"/> Do not recall or remember the information</td> </tr> </table> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p>					<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question	<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when	<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information
<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question									
<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when									
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information									

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Physician or Hospital
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____

Please check box if an additional sheet(s) of paper has been completed for this section.



When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE		YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A. Headaches requiring prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Sleep apnea/breathing difficulties while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. If you answered yes to 4a, check any reasons that apply				D. Recurrent fainting, weakness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Paralysis or chronic limb weakness or numbness/tingling in limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Due to birth control method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Due to breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G. Increased/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hysterectomy or menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H. Low or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have retained hardware, prosthesis or implants?				J. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K. Heartburn (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eye/limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M. Recurrent diarrhea and/or recurrent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any other prosthesis or implant (other than dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O. Blood, sugar, and/or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				P. Recurrent pain (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Q. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				R. Mass, cyst(s), or lump(s) in any body part including breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Male infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Female fertility/infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney, bladder or prostate disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Psoriasis, rosacea, acne or skin disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Cataract, glaucoma, eye or ear disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Minor depression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Anxiety/panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hepatitis C, D, E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hepatitis non A - E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you used marijuana within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(if yes, check appropriate box)			
<input type="checkbox"/> less than 4 times per month			
<input type="checkbox"/> 5-7 times per month			
<input type="checkbox"/> 8 or more times per month			

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever used illegal intravenous (IV) drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)			
<input type="checkbox"/> 0 per week <input type="checkbox"/> 1-14 per week <input type="checkbox"/> 15-26 per week <input type="checkbox"/> 27 or more per week			



6C. Medical Details

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
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Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
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<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
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Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
			Phone Number		FAX Number (Optional)
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <p><input type="checkbox"/> Do not understand the medical term(s) used in the question <input type="checkbox"/> Do not understand the question</p> <p><input type="checkbox"/> Do not know if you have the listed condition or symptom <input type="checkbox"/> Had the listed condition or symptom but cannot remember when</p> <p><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized <input type="checkbox"/> Do not recall or remember the information</p> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p> <p>_____</p>					



6C. Medical Details _ continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care								
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____								
Name of Condition/Illness			Address		Suite No.						
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City		State						
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<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when										
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information										

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care								
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____								
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<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information										

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Physician or Hospital
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____

Please check box if an additional sheet(s) of paper has been completed for this section.



When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE		YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A. Headaches requiring prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Sleep apnea/breathing difficulties while sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. If you answered yes to 4a, check any reasons that apply				D. Recurrent fainting, weakness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Paralysis or chronic limb weakness or numbness/tingling in limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Due to birth control method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Due to breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G. Increased/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hysterectomy or menopause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	H. Low or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have retained hardware, prosthesis or implants?				J. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	K. Heartburn (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eye/limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M. Recurrent diarrhea and/or recurrent vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Any other prosthesis or implant (other than dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O. Blood, sugar, and/or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				P. Recurrent pain (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Q. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				R. Mass, cyst(s), or lump(s) in any body part including breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Male infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Female fertility/infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney, bladder or prostate disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Psoriasis, rosacea, acne or skin disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Cataract, glaucoma, eye or ear disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Minor depression.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Anxiety/panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hepatitis C, D, E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Hepatitis non A - E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you used marijuana within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(if yes, check appropriate box)			
<input type="checkbox"/> less than 4 times per month			
<input type="checkbox"/> 5-7 times per month			
<input type="checkbox"/> 8 or more times per month			

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever used illegal intravenous (IV) drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)			
<input type="checkbox"/> 0 per week <input type="checkbox"/> 1-14 per week <input type="checkbox"/> 15-26 per week <input type="checkbox"/> 27 or more per week			

(Dependent 2)



6C. Medical Details

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
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Name of Condition/Illness			Address		Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) /and Results (attach additional pages as needed to provide complete information)			City		State
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Question # and Letter	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care		
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6C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

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Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty: <input type="checkbox"/> Pediatric <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Cardiac _____								
Name of Condition/Illness			Address		Suite No.						
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/and Results (attach additional pages as needed to provide complete information)			City		State						
			Phone Number		FAX Number (Optional)						
<p>If you answered "Not Sure" please check the box(es) that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Do not understand the medical term(s) used in the question</td> <td><input type="checkbox"/> Do not understand the question</td> </tr> <tr> <td><input type="checkbox"/> Do not know if you have the listed condition or symptom</td> <td><input type="checkbox"/> Had the listed condition or symptom but cannot remember when</td> </tr> <tr> <td><input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized</td> <td><input type="checkbox"/> Do not recall or remember the information</td> </tr> </table> <p>Please provide any additional information to provide a complete explanation of why you answered "Not Sure" (attach additional pages as needed to provide complete information).</p> <p>_____</p>						<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question	<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when	<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information
<input type="checkbox"/> Do not understand the medical term(s) used in the question	<input type="checkbox"/> Do not understand the question										
<input type="checkbox"/> Do not know if you have the listed condition or symptom	<input type="checkbox"/> Had the listed condition or symptom but cannot remember when										
<input type="checkbox"/> Do not recall exact time when you consulted a health care provider or were hospitalized	<input type="checkbox"/> Do not recall or remember the information										

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. No. of sheets attached

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Physician or Hospital
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____
					Name _____ Phone _____

Please check box if an additional sheet(s) of paper has been completed for this section.



You, the applicant, are solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-866-297-7647 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE:

If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement (all applicants)

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company nor any affiliated company shall have any liability to me or anyone else listed on it. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
6. I understand Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
7. If I purchase optional dental coverage, I understand that I may have a waiting period for the coverage of major services.
8. I understand that it is mandatory that I notify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied or delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting condition.
9. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross/Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross/Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.



10. By checking this box, I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors, and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.
11. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
12. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.

Term Life Insurance Coverage:

I am applying for the benefits provided by the policy indicated in Section 4. I understand that receipt of money with this application does not create coverage. Coverage will come into effect only on approval by Anthem Blue Cross Life and Health Insurance Company.

Initials

I understand that if Anthem Blue Cross Life and Health Insurance Company denies my application for term life coverage, I will be notified in writing and no benefit will be payable. I understand that (1) I alone am responsible for accurately completing this application and that (2) if I, or any person for whom life coverage is sought, incurs an illness or a change in medical health status during the period of time between the application signature date and the approved effective date of life coverage that is not disclosed in Section 6 of this application, notification to Anthem Blue Cross (our agent) of such illness or change in health status is mandatory.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes a claim containing false, incomplete or misleading information to obtain the proceeds of an insurance policy is guilty of a felony.

NOTE: Life insurance is to be underwritten by Anthem Blue Cross Life and Health Insurance Company.

Life Replacement Warning:

I understand that buying this life policy (if applicable) in order to discontinue or change an existing life policy is a mistake. Furthermore, I understand that my life insurance replacement requires a careful comparison of my existing policy and the replacing policy, my understanding of the facts, and my asking the company or agent that sold me my existing policy to give me information about it. In this way I would be sure I was making a decision that is in my best interest.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law. If Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in this application, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may rescind my plan/policy within the first 24 months from my effective date. I understand this means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will revoke my plan/policy as if it never existed back to the original Effective Date. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of our processing of your application.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may deny or rescind the entire plan/policy if it discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in this application. Enrollees/insureds other than the individual(s) whose information led to the rescission on such plans/policies may be able to obtain coverage as set forth in the section **Eligibility following Rescission**.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid on my behalf and that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will refund any premium paid by me, less my medical expenses that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid.



Eligibility following Rescission

For individual plans/policies that have been rescinded, eligible enrollees/insureds other than the individuals whose information led to the rescission on such plans/policies may continue coverage, without medical underwriting, in one of the following ways:

- enroll in a new individual plan/policy that provides equal benefits, or
- remain covered under the individual plan/policy that was rescinded.

In either instance, premium rates may be revised to reflect the number of persons on the plan/policy.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will notify in writing all enrollees/insureds of the right to coverage under an individual plan/policy, at a minimum, when it rescinds the individual plan/policy.

Eligible enrollees/insureds who continue coverage as a result of a rescinded plan/policy may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded plan/policy. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will credit any time that the eligible Insured was covered under the rescinded plan/policy. The time period in the new plan/policy for the pre-existing condition exclusion period will not be longer than the one in the plan/policy that was rescinded.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will provide 60 days for enrollees to accept the offered new individual plan/policy and this contract shall be effective as of the effective date of the original plan/policy and there shall be no lapse in coverage.

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me. I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 9) all persons applying for coverage agree that they have personally answered all health history questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 9).

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.*

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

IMPORTANT: ALL APPLICANTS AGE 18 AND OVER MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.



8. Authorization for Use of Protected Health Information

Primary Applicant's Name _____

NOTE: This form is not required if you are ONLY applying for HIPAA coverage.

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, the MIB, Inc. (MIB) and/or insurance support organizations. I further authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company to disclose protected health information it may collect about me to Consumer Reporting Agencies, MIB, Inc. and/or insurance support organizations for the purpose of fraud and abuse detection for this Application and for eligibility for benefits.

YOU HAVE THE RIGHT TO REQUEST HEALTH INFORMATION THAT MIB, INC. MAY HAVE ABOUT YOU AT NO EXPENSE TO YOU BY CALLING 1-866-692-6901.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for acceptance in a medically underwritten health plan/policy offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company for acceptance in one of its medically underwritten health plans/policies. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. The information disclosed pursuant to this authorization may be subject to redisclosure by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its agents and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

Printed name of Applicant/Member	Signature of Applicant/Member or his/her Legal Representative	Date
	X	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	X	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	X	

**If listed on your Application or Change Form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*

If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

A photocopy of this form will be as valid as the original.

You or an authorized representative have the right to receive a copy of this Authorization upon request.





Health care plans provided by Anthem Blue Cross. Insurance plans provided by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at www.mib.com.

Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



Language Assistance Services

English

Can you read the attached document? If not, we can have somebody help you read it. You may also be able to get this written in your language. For free help, please contact your agent.

Spanish

Puede usted leer este documento anexo? Si no, podemos asignarle alguien que le ayude. También puede recibir esto escrito en su idioma. Para asistencia gratuita, por favor contacte a su agente.

Chinese (Traditional)

您能讀懂所附文件嗎？如果不懂，我們可以請人幫您。也許您還可以收到中文版本。請聯絡您的代理人要求免費的協助。

Korean

첨부 서류를 읽으실 수 있습니까? 읽지 못하신다면 읽어드릴 사람을 구해드릴 수 있습니다. 한국어 번역본도 받으실 수 있습니다. 도움은 무료이며 담당 에이전트에게 연락하십시오.

Vietnamese

Quý vị đọc được tài liệu đính kèm không? Nếu không, chúng tôi sẽ cho người đọc giúp quý vị. Ngoài ra, quý vị cũng có thể được cấp tài liệu này bằng ngôn ngữ của quý vị. Vui lòng liên lạc với nhân viên đại diện của quý vị để được giúp đỡ miễn phí.

Tagalog

Kaya mo bang basahin ang nakakabit na dokumento? Kung hindi naman, maaaring patulungan ka namin sa ibang tao sa pagbasa nito. Maaari mo ring makuha ito na nasusulat sa iyong lengguwahe. Para sa libreng pagtulong, paki-kontakin ang iyong ahente.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-249-4844. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-249-4844. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-249-4844 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-249-4844 .Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-249-4844. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-249-4844번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Անվճար Լեզվական Օտարություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել սալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-249-4844 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-249-4844. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-249-4844までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویند مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره 1-866-249-4844 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵੀਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵੀਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-249-4844 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអាចអានសំឡេងអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទ មក យើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-249-4844 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងការពារប្រទេសកម្ពុជា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-249-4844. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntwaw ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntwaw tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-249-4844. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntwaw 1-800-927-4357. Hmong

